

DMH continues to see an increase in PNMI (residential assessment & treatment) spending, a trend that has been occurring over the past several years. The increase in DMH spending does not correspond to a notable increase in the use of PNMI statewide when looked at from an AHS/ IFS perspective. The two major factors contributing to DMH's spending are the increase in numbers of children placed in residential programs and length of stay in out-of-home placements. These factors have progressively increased for DMH placed children every year for the past several fiscal years. In the context of EPSDT, we know that the determination of medical necessity for residential assessment and treatment is addressed through several processes including the local team's decision to make a referral and the DMH and Case Review Committee processes to review the request. As AHS moves forward with the Integrated Family Services (IFS) initiative, it is our hope that we will begin to look at PNMI and waiver funding for out-of-home placements from an integrated approach with one budget to manage all requests.

- The DMH spending increase is seen in **number** of children/youth referred for and placed by DMH in residential facilities, acuity of need, and referrals to out-of-state facilities due to increased acuity and complexity. Out-of-State programs are explored after in-state options have been considered and ruled out.

DMH Total # Children in PNMI Placements by FY (in-state and out-of-state)

FY14*	FY13	FY12	FY11	FY10	FY09	5 yr average
41	75	68	63	56	59	64**

\*FY14 as of 10/11/13

\*\* 5 yr average is 64 admissions; up from last year's 5-yr average of 62 admissions.

DMH Out-of-State Placements (included in the above table)

FY14*	FY13	FY12	FY11
13	10	6	4

\*FY14 as of 10/11/13

- Division of Rate Setting tracks **bed day utilization** by placing department for in-state residential programs. This shows the increase in DMH utilization of in-state PNMI facilities across fiscal years. It also illustrates that compared to the DMH changes there has not been significant change in total AHS bed days utilized for in-state programs.

	FULL YEAR SFY11				FULL YEAR SFY12				FULL YEAR SFY13			
	SFY11 - July 1, 2010 through June 30, 2011				SFY12 - July 1, 2011 through June 30, 2012				SFY13 - July 1, 2012 through June 30, 2013			
	DCF	DMH	ADAP	Total Days Utilized	DCF	DMH	ADAP	Total Days Utilized	DCF	DMH	ADAP	Total Days Utilized
TOTALS w/ Closed Facilities	52,483	6,662	1,538	60,683	51,369	7,489	1,670	60,528	48,562	9,757	1,475	59,794
Change from prior FY					(1,114)	827	132	(155)	(2,807)	2,268	(195)	(734)

NOTE: DRS began tracking census data in SFY11.

NOTE: As SFY12 was a leap year, there is one extra day available for services in February compared to prior years.

NOTE: Eckerd Camp E-Wen-Akee closed 2/29/2012.

- This has resulted in a significant increase in DMH **spending**.

PNMI	Budget	Projected Spending	Difference
FY14*	\$3,488,260	\$4,385,705	(\$897,445)
FY13 **	\$2,051,251	\$4,041,174	(\$1,989,923)
FY12	\$2,051,251	\$3,014,842	(\$963,591)
FY11	\$2,649,038	\$2,723,209	(\$74,171)

\*FY14 projected spending as of 10/11/13

\*\* FY13 BAA added \$1.8M

## Why are we overspent?

### EPSDT:

If a provider determines that residential treatment is a “medical necessity” to address the child’s mental health needs, and the DMH agrees, the request for residential is approved and referred to an appropriately identified treatment program. DMH has lost several cases before the Human Services Board when we disagreed with the request for residential treatment, based on the argument of EPSDT’s medical necessity rule.

### Approvals, utilization review & length of stay:

DMH conducts a clinical review of the request for residential placement to determine if DMH will approved funding for the request. Then the case is brought to the inter-departmental Case Review Committee (CRC) for review. CRC was “established as a subcommittee of the State Interagency Team to achieve two objectives applying a consistent criterion: 1) To provide assistance to local teams as they identify, access and/or develop less restrictive treatment alternatives; and 2) When less restrictive alternatives are not appropriate, to assure the best possible match between child and residential treatment facility.”

DMH conducts utilization review of children/youth placed in residential (PNMI) programs to evaluate treatment progress and review discharge plans. Lengths of stay in placements continue to be high and some children may be in more than one out-of-home placement over the course of many years. Children placed in out-of-home placements by DMH are still in the custody of their parent/ legal guardian and are placed for clinical treatment purposes. However, some of these children/youth do not have a clear permanency plan; their families indicate that the child is not able to return home for a variety of reasons. In FY13, 36% of PNMI placements were children who were adopted or under guardianship by someone other than their biological parents.

